

# IRR ANNUAL SCREENING WORKSHEET

## PRIVACY ACT STATEMENT

**AUTHORITY:** Title 10, U.S.C., Sections 275 & 652

**PRINCIPAL PURPOSE:** To maintain essential records of Air Force Reservists, and identify specific personnel capabilities.

**ROUTINE USES:** Disclosure may be made to any Department of Defense component or, upon request, to other Federal, state, or local agencies in pursuit of their official duties and may be used for other lawful purposes including law enforcement and litigation.

**DISCLOSURE: MANDATORY.** Failure to respond could cause incorrect priority for recall in the event of national mobilization and is a violation of Federal law.

**INSTRUCTIONS:** You must keep the Air Reserve Personnel Center (ARPC), the appointed agent of the Secretary of the Air Force, informed of your current address, physical condition, and availability for military service. To help you meet these responsibilities, information from your computer record maintained by ARPC is shown below. Please verify that this information is correct. If it is not, see the attached instruction sheet.

SECTION I PAS AND DATE			
PART A - CURRENT INFORMATION		PART B - CORRECTIONS REQUIRED	
1. GRADE	2. SSN	1. GRADE	2. SSN
3. MARITAL STATUS	4. CITIZENSHIP	3. MARITAL STATUS	4. CITIZENSHIP
5. DATE OF LAST PHYSICAL	6. PRIMARY AFSC	5. DATE OF LAST PHYSICAL	6. PRIMARY AFSC
NAME AND ADDRESS		7a. NAME	
		7b. ADDRESS <i>(Please include ZIP + 4)</i>	
8. ETO/ETS	9. SEX	8. ETO/ETS	9. SEX
10. NO. OF DEPENDENTS	11. NO. OF DEPENDENTS IN HOUSEHOLD	10. NO. OF DEPENDENTS	11. NO. OF DEPENDENTS IN HOUSEHOLD
12. ADDITIONAL EDUCATION ACQUIRED		12. ADDITIONAL EDUCATION ACQUIRED <i>(Send Documentation to ARPC)</i>	
12a. MAJOR FIELD OF STUDY		12A. MAJOR FIELD OF STUDY	
13. HOME PHONE	14. BUSINESS PHONE	13. HOME PHONE	14. BUSINESS PHONE
15. PRIMARY CIVILIAN OCCUPATION		15. PRIMARY CIVILIAN OCCUPATION	
		15a. MAIN DUTIES	
FOR IRR MEMBERS IN MEDICAL SPECIALTIES ONLY			
16. CREDENTIALLED MEDICAL SPECIALITY		16. CREDENTIALLED MEDICAL SPECIALTY	
17. STATE LICENSED		17. STATE LICENSED	
18. LICENSE NUMBER		18. LICENSE NUMBER	
19. LICENSE EXPIRATION DATE		19. LICENSE EXPIRATION DATE	
FOR MEMBERS WITH MILITARY SPOUSES			
20. SPOUSE'S SVC BRANCH	21. SPOUSE'S COMPONENT	20. SPOUSE'S SVC BRANCH	21. SPOUSE'S COMPONENT <input type="checkbox"/> REG <input type="checkbox"/> RES <input type="checkbox"/> GUARD <input type="checkbox"/> RET
22. SPOUSE'S GRADE STATUS	23. SPOUSE'S SSN	22. SPOUSE'S GRADE STATUS <input type="checkbox"/> ENLISTED <input type="checkbox"/> OFFICER	23. SPOUSE'S SSN
PART C SCREENING CERTIFICATION <i>(To be completed by screening official)</i>			
1. MEMBER HAS PROVIDED PROOF TO SUBSTANTIATE CHANGES MADE IN ITEMS: <i>(Circle appropriate numbers)</i>  1      2      3      4      7a      8      9      10		I certify I have personally reviewed the documentation and it meets current criteria.	
		2. SIGNATURE	3. DATE
4. NAME <i>(Print Name, Grade, and Organization)</i>			

<b>SECTION II</b>	<b>ADDITIONAL MOBILIZATION INFORMATION</b>
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1. ARE YOU A VA PENSION/DISABILITY RECIPIENT? <input type="checkbox"/> NO <input type="checkbox"/> YES	
2. HAVE YOU HAD ANY CIVIL CONVICTIONS SINCE YOUR LAST SERVICE OTHER THAN MINOR TRAFFIC OFFENSES? <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, complete the following:)	
A. OFFENSE	D. PLACE OF ARREST
B. PLEA	E. SENTENCE RECEIVED
C. DATE OF ARREST	F. COURT OF JURISDICTION
G. IF CURRENTLY ON PROBATION, PROVIDE PROBATION OFFICER'S NAME AND COMPLETE MAILING ADDRESS	
3. DO YOU HAVE AN ARMED FORCES OF THE UNITED STATES IDENTIFICATION CARD, DD FORM 2 AF (RES)?  <input type="checkbox"/> NO <input type="checkbox"/> YES	4. MY CURRENT MEDICAL CONDITION IS:  <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD  <input type="checkbox"/> POOR (If poor, describe problem in Item 5 "REMARKS")
5. REMARKS	

<b>SECTION III</b>	<b>MEMBER'S CERTIFICATION</b>
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STATEMENT OF UNDERSTANDING - DEPENDENT CARE RESPONSIBILITIES (AFR 35-59) I UNDERSTAND I AM RESPONSIBLE FOR MAKING ADEQUATE DEPENDENT CARE ARRANGEMENTS IN ADVANCE TO ENSURE THAT I AM AVAILABLE TO MEET MY MILITARY DUTIES AND OBLIGATIONS. MEMBER'S INITIALS _____	
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. (A knowingly false certification can subject you to a fine of \$5000.00 or 5 years imprisonment or both.)	
2. MEMBER'S SIGNATURE	3. DATE

<b>SECTION IV</b> <i>(All blocks must be completed)</i>	<b>FOR MEDICAL PERSONNEL ONLY</b>	<i>(To be completed by screening official)</i>
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1. SIGNIFICANT INTERVAL HISTORY		
2. MEMBER IS: (QUALIFIED)    (QUESTIONABLY QUALIFIED)    (NOT QUALIFIED)    FOR WORLDWIDE SERVICE.    (CIRCLE ONE)		
3. REASON FOR QUESTIONABLE OR NOT QUALIFIED FOR WORLDWIDE SERVICE		
4. RECOMMENDATIONS		
5. HEALTH CARE PROVIDER (Print or stamp)	SIGNATURE	DATE